The Politics and Anti-Politics of the Global Fund Experiment

Politics and Anti-politics of the Global Fund Experiment: Understanding Partnership and Bureaucratic expansion in Uganda

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The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a public-private partnership and international financing institution that works to attract and distribute additional funding for the 'big three' infectious diseases: HIV/AIDS, tuberculosis and malaria. Offering a new funding channel for existing donors and new benefactors, since its launch in 2002, the Fund has "become the main financier of programs to fight AIDS, TB and malaria, with approved funding of US$ 22.9 billion for more than 1,000 programs in 151 countries".[1] It is an example of a new modality of development health financing – "Multi-Bi Financing" – that differs considerably from more traditional models of development in the health sector in certain crucial ways, in particular: "a wider set of stakeholders that include non-state institutions, narrower problem-based mandates, financing based on voluntary contributions, no country presence, and legitimacy based on effectiveness, not process" (Shridar 2012: 2).

The GFATM is thus one manifestation of a number of shifts in health development we have witnessed over the last 15 years. A range of forces, both economic and political, have resulted in a reconfiguration of how we understand and approach health at the global level. As Fidler (2009) has pointed out, this re-conceptualization has been associated with considerable increased finances and resources, and includes the following shifts: health being increasingly framed as a security issue (cf Ingram 2005); the emergence of new international governance regimes, such as the WHOs International Health Regulations (IHR); new assemblages of organizations dealing with certain infective threats, like the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM); the leading economic powers tabling health issues at global summits and meetings; the shifting geopolitical relations, both around states, such as China's ascendancy and non-governmental organizations like Médicins Sans Frontières (MSF); and the rise of the Gates Foundation in particular, with their investment in health (Birn 2005).

This increased focus on global health issues has become coupled with a shift in focus of development discourse. With the emergence of the Millennium Development Goals (MDGs), development interventions themselves became more weighted towards health

oriented targets (Nayar and Razum 2006). MDG Five and Six, in particular, are to "improve maternal health" and "combat HIV/AIDS, malaria and other diseases" respectively. In macro-economic terms, the resulting increase in development assistance for health, that is, all flows into health from public and private institutions by those providing "development assistance to low-income and middle-income countries" has increased from $5.6 billion in 1990 to $21.8 billion in 2007 (Ravishankar et al. 2009). For those of us immersed in health and development work, in both practice and research, we have had to attempt to keep abreast of and understand these shifts and their implications. Lakoff (2010) argues, for example, that there are two basic "regimes" of global health, one emergent around security and in particular "governing pathogens" and the other a form of "humanitarian biomedicine" symbolized by MSF and Gates.

In this paper we provide empirical flesh to the bones of the more theoretical and discursive observations of many of the authors (like those above) charting global health and development interventions and their associated changes. In particular we explore the implications of these shifts and the resultant new modalities of aid in the context of Uganda. We focus in particular on GFATM. The article draws on the empirical research in Uganda, and direct experiences at the interface of the Global Fund and Government, to explore how the GFATM vision to be a simple financing instrument has played out at the country level. During 2007 and 2008 the first author researched into the process of developing a GFATM country proposal in Uganda and investigated the manner in which the existing health sector infrastructure there was being appropriated for GFATM activities, part of a broader study into aid coordination measures in the country's health sector. She used a mixture of qualitative methods (in-depth interview, discourse analysis, observation and triangulation) and focused on those actors - namely representatives from government, donor agencies, civil society and the private not-for-profit sector - involved in attempting to coordinate this. In addition we draw on the experiences of the second author, who worked in Nepal in 2008 at the invitation of the government, on implementing the GFTAM funded TB program in country.

Firstly we introduce the Global Fund and its modalities of functioning, and in the context of Uganda. The findings are then presented under two main headings: *partnership* and *bureaucracy*. These overlapping themes have defined the GFATM experiment, and shed some light on the role of the fund, and country's attempts to coordinate these activities. *Partnership* reflects on the GFATM's particular modus operandi, specifically its decision to operate through a partnership model. *Bureaucracy* examines the process of accessing GFATM monies via Round funding and the mushrooming governance structures required to oversee the GFATM's work in country. While some authors and the GFATM itself have suggested that an inability to manage risk is the root of the problem, we turn to the corpus of anthropology writing on development that frames these issues as forms of governmentality. Such a reframing allows us to interpret the work and impact of the GFATM outside of their own frame of reference, and paves the way for a rethinking of its approach to financial disbursement.

Introducing GFATM and its work in Uganda

Conceptualized as "a response to the perceived failures of 'big aid'" (Rogerson, Hewitt and Waldenberg 2004: 20), Global Health Initiatives (GHIs) have reconfigured the landscape of international donor assistance by raising the level of resources available for health in low and middle-income countries, and channeling it into disease-specific, or "vertical" interventions. Distinguishing features of GHIs include partnership between the public and private and/or not-for-profit sectors, a stated desire for "lean and efficient organizational structures and an emphasis on linking inputs to quantifiable results" (WHO 2008: 3). The analogy of an experiment, while to some sense applicable to all development aid (cf. Riddell 2007; Banerjee and Duflo 2011), is particularly pertinent to the GHIs. In 2008 the World Health Organization identified over eighty GHIs in operation, all with different funding models, guiding principles and management styles (WHO 2008). It is the scale of the Global Fund experiment – approving grants worth £22.9 billion in 151 countries - that demands it receive special attention.

The Global Fund acts primarily as a financial disbursement mechanism. And with its rise to prominence they brought with the money and resources a particular organizational form, in particular one to draw on the strengths seen in the management of the private sector to that of health and development management. They have developed a mechanism called "performance-based funding", an idea that emerged from the US in tertiary education in the 1970s, and is applied to "ensure the accountability, efficiency and effectiveness of programs being funded."[2] Their mantra, repeated incessantly, is "Raise it; invest it and prove it", and the results should be demonstrated against performance based targets.

The original Global Fund *Framework Document* stated its idea of "a simplified, rapid, innovative process with efficient and effective disbursement mechanisms," that would support national strategies and give due priority to the most affected countries (GFATM 2002:2-3).Ten years later, and it becomes clear that the GFATM has deviated from its original aims and mission. Forced to cancel its Eleventh Round of funding due to a shortfall in donor pledges, the GFATM is now fighting to survive: recent months have seen the Fund's leadership, governance structure and operations completely overhauled (Garmaise 2012a; GFATM 2011a; GFATM 2011b; GFATM 2011c; GFATM 2012). The discrepancy between donor pledges and actual contributions in 2011 has been attributed to a number of factors: the global economic crisis, the slow disbursement rate of the fund and renewed concerns over corruption (Garmaise 2011; GFATM 2011c; Rivers 2011b; Zarocostas 2012). Yet discounting the global economic crisis (which has acted as a catalyst), the latter two factors can be summarized as "a loss of partner and donor confidence," and this was a development clearly portended for the Fund in *The Five-Year Evaluation of the GFATM* (Macro International 2009:46). Moreover, it's something partners in recipient countries have been hinting toward for some time, where disquiet has grown over the discrepancy between what the Fund originally promised – rapid, scaled-up funding for the 'big three' - and what it's delivered – bureaucracy, expense, disruption and (all too often) disappointment. The GFATM *at five* was warned that the "bubble of unrealistic expectations" that accompanied its creation could prove its undoing (Macro International 2009:7). The GFATM *at ten* is bearing

the brunt of having ignored that warning. An institutional form in flux, the Fund has oft been likened to a "large scale experiment" (Oomman, Bernstein and Rosenzweig 2007:3).

The GFATM is not an implementing agency – it is conceived of as a financial instrument, designed to mobilize and distribute funds. Centrally it consists of a Secretariat, Technical Review Panels (TRPs) that review country proposals, and a Board responsible for governance. In country the most important entity is the 'Country Coordination Mechanism': a partnership forum composed of all the key stakeholders involved in a country's response to the 'big three' (including government, civil society, the private sector and infected communities). This entity is charged with submitting funding proposals to the Global Fund, nominating the entities accountable for administering the funding, and overseeing grant implementation. The Principle Recipients (PRs) – in Uganda, the Ministry of Finance, Planning and Economic Development and The AIDS Support Organization - receive the resources, and are linked to Sub-Recipients (SR) who provide the services and are responsible to the PRs.

As GFATM does not have an in country presence, the "eyes and ears" of the organization, financial and programmatic auditing is undertaken by the Local Fund Agent (LFA), in this case PricewaterhouseCoopers.

In addition the Fund has a very particular funding mechanism that involves a system of 'Round funding', whereby countries are permitted to apply for new or additional Global Fund funding on an annual basis for one or more of the disease components. Each round has been accompanied by specific guidelines (laid out in 'Calls for Proposals') which recipient countries must adhere to if they are to secure funding. The CCM is overall responsible for the development of these round calls, and once submitted and reviewed by TPRs, final agreement and contracts and further disbursement of grants is dependent on meeting a list of Condition Precedents (CPs) determined by GFATM centrally.

GFATM is one of a number of donors supporting Uganda, a country that fulfills the World Bank's definition of Less Developed Country, which, as Ferguson has suggested establishes it as "a country with all the right deficiencies, the sort that 'development'

institutions can easily latch onto" (Ferguson 1990:70). The nature of aid flows to Uganda points to a culture of aid dependency, with donors providing more than 50% of the health budget. On the one hand Uganda has garnered a reputation for being a 'donor darling',[3] boasting an impressive rate of economic growth, an innovative approach to policy making (Uganda's strategy paper the *Poverty Eradication Action Plan* is regarded as the blueprint for the World Bank's Poverty Reduction Strategy Papers) and a willingness to work with external partners. It is also highly praised for reductions made to its HIV/AIDS prevalence rate in the 1990s (cf. Parkhurst 2002). On the other hand, donors have grown progressively wary of the political climate in Uganda since the turn of the millennium. Concerns over governance (stemming from the slow transition to multiparty politics, attacks on the opposition, the repeal of presidential term limits and the ongoing war in northern Uganda) have merged with concerns over corruption, and culminated in donor threats to withdraw aid (see for example Observer Media Ltd 2010).

In 2005, it was discovered that approximately US$1.5 million of GFATM monies (3.2 billion Ugandan Shillings) had been misappropriated in Uganda's health sector (Mugisa and Nsambu 2009).[1] This led to the Global Fund's three-month suspension and a review of the way in which the Fund is managed in Uganda, the implications of which we outline below. We turn next to the empirical findings and to how the Fund attempted to stabilize and implement its vision and presence in country.

PARTNERSHIP

All parties interviewed agreed that the partnership between the various stakeholders in Uganda's health sector *costs* both financially and in terms of time expended. Development Partners have been asked to contribute funds for the preparation of GFATM applications proposals, and to support the implementation of grants through the funding of technical assistance. These Development Partners are also vocal supporters of Uganda's sector-wide approach in the health sector and sit on the country's Health Sector Advisory Committee: the country's most important multi-stakeholder forum for health. In 2007 this forum became one

half of the Country Coordinating Mechanism (CCM) for the GFATM; a development which diverted the focus of the sector-wide forum along vertical lines.

This wasn't the working relationship envisaged by contributing partners at the time of the GFATM's inception:

> "Everything right now [in Uganda] seems to center on the Global Fund. It's just driving me crazy… And now HPAC [Health Policy Advisory Committee] and PC [Partnership Committee of Uganda AIDS Commission] are somehow joined together as CCM and… it also means everything focuses on Global Fund. And to me it's just a financing mechanism. It's a shame the Ministry [of Health] has to dedicate so much time to it. At the same time they don't want to do it so they hire eight *really* expensive consultants to write the proposal. But that's not right either…And we're big donors to the Global Fund but I've also talked to our Swedish Board members about this and they've taken note. They said it shouldn't be like this. It shouldn't be that AIDS Commissions and CCMs recruit eight external consultants to do proposals. And then they ask the same donors that are putting money into the Global Fund to fund those consultants. It's sick. They were shocked when I told them but that's the way it is" (SIDA Interview 22nd May 2008).

As has been described, the envisioned light touch of the GFATM, in particular its determination to have no country presence, has led to:

> "an increased demand on the staff of other organizations to do the Global Fund's in-country project development, proposal writing and follow-up work…It has also created in other organizations, especially WHO, a direct financial burden for unfunded services…" (Shakow 2006:21).

We will return to the notion of 'unfunded mandates' and the work of the WHO in Uganda shortly. First however, we turn to the level of the GFATM architecture, to get a sense of how this situation came about.

GHIs are conceptualized as an alternative to 'business as usual' in the provision of development aid (Rogerson *et al.* 2004). For the GFATM founders, this was reflected in the early years in statements about what the Fund would *not* do, as opposed to how, beyond simply mobilizing and distributing funding, the GFATM would rally its partners to "make the money work" (GTT 2005). What was stated explicitly was that the Fund wouldn't mirror the traditional donor modus operandi. It wouldn't maintain a country presence. It wouldn't burden countries with high transaction costs or slow disbursement processes. And it wouldn't

politicize aid. Finally, it was adamant that the format of the country proposal "should not be overly elaborate and not impose undue burden on the countries" (GFATM 2002:7). For some the determination of the GFATM architects to set themselves apart from "old, established agencies" (Shakow 2006:43) has been blamed for creating tensions with their counterparts at the World Bank and UN agencies (Macro International 2009). It has certainly had a negative impact on the nature of partnership as perceived in Uganda.

The *Five-Year Evaluation of the GFATM* concluded that the GFATM lacked an overarching strategic vision. Subsequently "the ad hoc growth and reactive evolution of the Global Fund architecture has brought with it increased procedural complexities and a spate of policy that have led to confusion, and in some cases, contradictions" (Macro International 2009:540). As it stands, collaborating organizations are left to "wait and see" where the Fund is going, unable to adequately plan their own strategic interventions. Two key areas with a direct bearing on the partnership model and where the Fund is only now – a decade on – preparing to issue guidance are the respective roles and responsibilities of partners and the funding of technical assistance (GFATM 2011a; GFATM 2011c).

The Ugandan case study demonstrates the impact of the GFATM's evolving and shifting polices at the country level. From turning down the country's integrated proposal in Round 1 - the Fund at this stage demanded that the disease components be separated and that the country set up a Project Management Unit (PMU) to manage the grants – the GFATM demanded an integrated proposal and endorsed the country's *Long-Term Institutional Arrangements* for managing the grants in Round 7. In addition to this policy shift, there was the high-profile mismanagement of the GFATM grants in Uganda in 2005 and the Fund's subsequent three-month suspension - an incident which reflected on the GFATM in international circles as being able to demonstrate its punitive muscle (Shakow 2006; Sidibe, Ramiah and Buse 2006). In Uganda, however, perceptions were less positive as the Project Management Unit the GFATM had insisted upon installing (and which sat, dislocated from the state apparatus) was found to have provided the perfect vehicle for the mismanagement.

A high-level Ministry of Health official stated in interview that the PMU had been forced on Uganda and had caused a lot of confusion. He suggested there had been no alignment with the government, no proper supervision and a lack of direction. He also pointed out that the PMU had led to a lot of duplication (MoH Interview 7th April 2008). His account reiterated some of the original concerns voiced about the PMU in an earlier study (Donoghue *et al.* 2005:44). Biesma *et al.* have also commented that the government of Uganda and its Development Partners regarded the PMU in 2003 "as a distortion of Uganda's policy of channeling all funds to support a coordinated national health sector strategy" (Biesma *et al.* 2009:242).

Such findings evoke the unequal 'partnership' that still exists between aid recipients and their donors where the recipient country is powerless to overturn the donor's prescriptions. This localization of international GFATM policy has assumed the "fallacy of the level playing field" and overlooked the unequal power relations inherent in these donor country relationships (Manderson and Whiteford 2000). That the GFATM has since rescinded both its decision to operate through a PMU and insisted upon a disaggregated proposal is again indicative of the Fund's "trial and error" approach (WHO 2008:8), but still points to it riding roughshod over Ugandan state sovereignty.

Finally in this section we turn to the relationship between the WHO and GFATM. The financial and opportunity costs incurred through the trial and error approach of Global Health Initiatives such as the GFATM were underscored in 2005, when the Global Task Team (GTT) on Improving AIDS Coordination Among Multilateral Institutions and International Donors identified the UN's "unfunded mandate" (GTT 2005:15). This relates to the mismatch between the need and availability of UN technical support being requested by countries to finance proposal development and to support the scale up of disease responses in accordance with the GHIs. In short, the GTT noted that the rise in demand didn't correlate with any additional resources for the UN system. Unfunded mandates have since been deemed applicable to partner organizations outside the UN (Shakow 2006).

The demands placed on WHO country offices and their partners by the GFATM were formally recognized in 2008 with the launch of the WHO initiative *Maximizing Positive Synergies between Health Systems and Global Health Initiatives* (WHO 2008). Yet the Ugandan case material establishes that WHO's central and regional tiers have been helping host countries navigate the GFATM application strictures for many years. At the international level, this has involved WHO posting technical guidelines online to assist countries in the writing of countries' proposals. At the country level, WHO's support in Uganda has ranged from proposal development (Ugandan staff have attended tailored WHO trainings on how to compose GFATM proposals) to temporarily assuming the role of third-party procurement agent for the GFATM following the 2005 suspension, thus instrumentally restarting the flow of monies in country. Asked about this latter role – which WHO had originally agreed to take on for one year but which it was found to be continuing to do past the original deadline of 30th September 2007 – the Drugs and Essential Medicines National Professional Officer conceded:

> "We are not comfortable with continuing because it's not consistent with our core mandate. We only came in because we were to fill a gap and help the government not to lose the money. It has consumed a lot of our time and because it is not our core mandate we have not done it so well" (WHO Interview 8th November 2007).

This practice is not in line the WHO's core mandate. Moreover, another comment made by a WHO professional officer in Uganda: "it is one of our core activities to support the Ministry [of Health] in resource mobilization" (WHO Interview 6th May 2008), suggest this too is an activity beyond their official remit. Viewed in this light, the GFATM is clearly dependent on WHO input to carry out its core functions.

Maximizing Positive Synergies is clear that any successes the GHIs have enjoyed with partners to-date have come about by happy accident rather than design. Moreover, it is adamant that "The time has come to move from the current situation where outcomes are often subject to trial and error and reliant on goodwill, to a more systematic framework of active management by all stakeholders" (WHO 2008:8). To date, however, for GFATM to

manage its functions it has clearly moved beyond its envisaged partnership model to draw heavily and in a generally unacknowledged way on the resources of those with whom it works.

BUREAUCRACY

The fieldwork demonstrates how the failure of the GFATM to successfully operationalize its partnership model in its first decade has contributed to the bureaucratization of GFATM procedures and governance structures at the level of the recipient country. This section presents data on the application and disbursement processes in Uganda, the role of the Country Coordinating Mechanism and the use of external agencies to provide fiduciary oversight over GFATM monies. In particular, we focus on the shifting terrain of the development of so-called Round funding as a way of charting this increasing bureaucratization.

Global Fund proposals: the growing complexity of Round funding

This research was carried out when Uganda was involved in funding Rounds 7 and 8. Earlier, the GFATM commissioned a country tracking study in 2005 capturing the early years of the Fund's operation in Uganda (Donoghue *et al.* 2005). A significant finding was that for GFATM funding Round 1, Uganda's Ministry of Health devised a cross-cutting proposal for the three diseases, reflecting the country's burgeoning health SWAp and its commitment to decentralization in the sector. The country and its Development Partners were thus dismayed when the proposal was rejected by the Technical Review Panel, which asked that the proposal be redrafted and broken down into three component parts along disease lines.

Donoghue *et al.* have suggested that Uganda's experience with Round 1 had "quite a profound impact, which appeared to influence Uganda's subsequent approach to the Fund" (Donoghue *et al.* 2005:9). In short, the government was left disillusioned with the GFATM, feeling that it didn't understand what Uganda was trying to achieve with its sector-wide approach in health.

While there was some improvement in what was perceived as the GFATM's sensitivity to country processes during Round 2, for Rounds 3 and 4 the Ministry of Health (MoH) decided to outsource the proposal drafting to external consultants – a process increasingly seen in diverse development terrains - reporting that "the Round 1 process had consumed too much time and energy of senior MoH staff" (Donoghue *et al.* 2005:11). Moreover, it was noted that the proposal preparation guidelines, which had been considered as inadequate for Round 1, had become overly complicated by Round 3. By Round 4 the process of developing the GFATM proposal was reported to have become better internalized in Uganda. Nevertheless Donoghue *et al.* reported that "Lack of certainty about the rules and requirements persisted into later rounds" (Donoghue *et al.* 2005:12). Such uncertainty was found to be consistent with the experience of other countries (GFATM 2006).

By Round 5 despite conscious efforts to avoid excessive amounts of information being submitted in proposals, the level of detail had in fact increased, as information on country context and capacity became requisite inserts for the application. It was noted in a GFATM document that the volume of information would likely escalate again as data became more systematically available at the country level and countries began to comment on the performance of their previous grants (GFATM 2006). As a WHO interviewee stated:

> "The Global Fund says they're simplifying now but there are areas where you get repetition. You answer the question and then you go ahead and think 'isn't this the same question from before that they're asking again?' If you want the money you still have to answer it" (WHO Interview 22nd April 2008).

The increased bureaucratization of the Fund's application procedure has created a professional cadre of workers who focus on form-filling and application writing. This had been added to by Round 8, by which time the proposal guidelines had changed again making broad stakeholder consultation a further pre-condition for funding success.

By May 2008, the stakeholders in Uganda's health SWAp and multi-sectoral HIV/AIDS partnership were preparing the GFATM country proposal for Round 8. This was the context for the complaint of the Development Partner: "Everything right now seems to

center on the Global Fund. It's just driving me crazy…" (SIDA Interview 22nd May 2008). Beyond mentioning that the MoH were now so fed up with the GFATM's time-heavy bureaucratic processes that they have hired "eight *really* expensive consultants," the same donor went on to attach a figure to the financial cost of Uganda's Round 8 application:

> "We got this budget yesterday for the Global Fund and for them to put this together…is going to cost – this is just for curiosity – Uganda Shillings 653 million [approximately US$347,000]. This is including field consultations, and then of course you have full-board for 15 participants in all the districts, transport refund, DSA for the consultation team, DSA for the drive, airtime. And then you have like a writing retreat - full board in Jinja for writing and drafting things; and then you have the overall lead consultant" (SIDA Interview 22nd May 2008).

Moreover, a costly issue involving the hired consultants is acknowledged:

> "Actually all these consultants are local because we asked [for that] which is good but they are recruited through a firm in Nairobi so they have international rates…the Partnership Fund which you know they can use for their own discretion is paying lead consultants US $600 to do this proposal" (SIDA Interview 22nd May 2008).

These added layers the GFATM has incorporated into the revised application process have resulted in at least two new financial costs to the applicant country: the outlay associated with ensuring broad stakeholder consultation and the expense involved in hiring external expertise. The former now means there is a need to conduct district reconnaissance missions and extensive field consultations throughout Uganda. The latter, that anything involving funding can be turned into a specialization. That local consultants can charge international rates demonstrates that the knowledge required to produce a successful proposal is increasingly specialized. It also shows that the GFATM has multiple unintended effects in recipient countries; in this instance the envisaged reward has driven up the amount the country is willing to invest on its proposal and created a lucrative job market for would-be consultants. Funds for this come from one of two sources. The AIDS Partnership Fund, a voluntary basket fund that Uganda's AIDS Development Partners pay into, situated within the Uganda AIDS Commission. Uganda's Health Development Partners also maintain a

Partnership Fund, situated in the Department of Planning at the Ministry of Health, but it is a much smaller pot, originally conceived of (as once they both would have been) to cover the administrative costs of partnership/coordination at the country level over the course of a given year.

In addition, the Chair of the AIDS Development Partners recounted a problem the malaria and TB partners were having mobilizing the requisite resources to prepare their parts of the integrated proposal. She noted that while the AIDS Partners had a dedicated budget line in their Partnership Fund for developing the HIV component of the proposal - and had previously bankrolled the proposal for all three disease components in Round 7 – the Health Partnership was being asked to fund the malaria and TB components of the GFATM proposal for the first time, causing real difficulties. She noted that the Private Secretary of the Ministry of Health had said "she was going to look around for funding, so that we could jointly fund this process" (Irish Aid Interview 20th May 2008).

In sum, since Uganda submitted its first country proposal in Round 1, the procedural complexity of the GFATM application process has increased exponentially. The bureaucratization of what was originally envisaged as a simple aid instrument is now such that the application is too complex and time consuming for in country partners to produce alone. This has led to the creation of a new line item for Partnership Funds in Uganda: 'external expertise for the Global Fund'.

Uganda's Long-Term Institutional Arrangements

In light of the 2005 mismanagement, the Ugandan government was asked to devise new arrangements for overseeing the management of GFATM grants. The resultant Long-Term Institutional Arrangements (LTIAs) resulted in "the realignment of all funding mechanisms to existing institutional arrangements" (Doc 1. 2006:5).[4] In keeping with the tenets of the *Paris Declaration on Aid Effectiveness* (Paris High-Level Forum 2005), these principles are now viewed as central to all aid relations in Uganda. The central premise is that aid donors should use existing systems and structures within Uganda, contributing to national capacity

where needed. Accordingly, it was decided that existing coordination structures in the Health and HIV/AIDS Partnerships should take on the role of Country Coordinating Mechanism (CCM) for the GFATM: with the Health Policy Advisory Committee (and its respective Technical Working Groups) subsuming CCM functions for the management of the TB and malaria grants, and the Partnership Committee of Uganda AIDS Commission (and its respective working groups) subsuming respective functions for Uganda's multi-sectoral HIV/AIDS response.

The LTIAs set out an expanded scope of work for the HPAC and the PC in line with their revised remit as CCM. The guidelines for the HPAC, signals a clear increase in workloads for both fora. Far exceeding proposal development, long-term oversight and reporting commitments were given to the CCM, although these activities were never intended to be dominant items on the HPAC and PC agendas. Instead, CCM business was supposed to be confined to quarterly meetings held under the official auspices of 'CCM', and to the occasional ad hoc meeting if and when the need should arise (Irish Aid Interview 20th May 2008). All agreed that GFATM issues were consuming a lot more time in the monthly HPAC and PC meetings than initially expected. The Chair of the Health Development Partners (HDPs) even highlighted it at the biennial meeting of the National Health Assembly in 2007. He underlined the concern that the GFATM was taking up increasing time and energy in the HPAC forum, undermining its prescribed role to influence policy. A year later he noted that things had not improved (BTC Interview 10th April 2008). He explained that the technical working groups were not yet operating well, meaning that technical issues concerning the GFATM were filtering up onto the HPAC agenda. He felt that GFATM matters would likely continue to skew the agenda of the sector forum for some time.

At one level this encroachment of the GFATM on the HPAC agenda was seen as "really, really tedious" (MoH/Danida Interview 9th May 2008). But this was simultaneously undermining the prescribed role of the HPAC to determine policy. It was in this vein that a MoH official expressed his dismay that the HPAC forum - established to support the entire health sector - was still being dominated by GFATM issues by mid-April 2008. These

complaints point to a "deviation" of the forum's core mandate that resonates with the previous WHO case study (Interview 16th April 2008). This finding certainly supports the WHO suggestion that GHIs have re-ignited the horizontal versus vertical debate over health (WHO 2009). The notion that the GFATM is an anathema to SWAps is an issue that has frequently been speculated upon in the writings on the issue (Donoghue *et al.* 2005; GTT 2005; Oliveira-Cruz *et al.* 2006; GFATM 2006; WHO 2008; WHO 2009).

However, Uganda's success in winning HIV/AIDS and malaria grants in Round 7 attest that the new LTIAs have indeed sown the seeds for renewed GFATM confidence in country. The government and its Development Partners are behind the LTIAs and the idea of using national systems to manage the GFATM funds, as was originally proposed in Round 1. One MoH staff member impressed that the LTIAs were nothing new in Uganda:

> "I don't think they're anything revolutionary, no…. five years ago – so when the Global Fund started – as a country we prepared one proposal for the three diseases with a systems approach, and we would have preferred to have run it through the government systems. We went to the Global Fund and they didn't like it. They threw it out and they told us they wanted a whole separate back up. They went down that road, they were seriously burnt…they came back to ask how we would really like to go about it" (MoH/Danida Interview 9th May 2008).

This same position on the LTIAs was reinforced repeatedly in the country interviews, in which interviewees often cited Uganda's 2001 'Partnership Principles' (MoFPED 2001:3-4) as the original template for the arrangements. And while the turnaround in the GFATM's approach to Uganda aptly epitomizes the trial and error approach of the Fund, it is Uganda who has borne the brunt of all the iterations.

We turn now to the outsourcing of the GFATM's fiduciary and management functions to external agencies. In Uganda (as elsewhere) the international accounting firms PricewaterhouseCoopers, provide audit oversight over GFATM monies. This was criticized in the *Five-Year Evaluation of the GFATM*:

> "Absent clear policy intent and despite concerns expressed by some members of the board, the Secretariat took the path of contracting out in-country fiduciary functions

> and hiring in additional program oversight capacities, rather than partnering with other international entities. What followed was a continuous cycle of Global Fund hiring in Geneva to catch up with the oversight requirements of the Fund's expanding portfolio, with the Secretariat to take on functions that arguably other partners were in a better position to execute on the Global Fund's behalf" (Macro International 2009: 36).

These developments have increased the overheads involved in managing the grants. In short, this too has hiked up the costs incurred in applicant countries, reflecting the Fund's reluctance to delegate meaningful responsibility to partners.

In turn, in Geneva the GFATM has turned to the Office of the Inspector General (OIG), an internal auditing body. This has also been criticized for being overzealous, bureaucratic and at times overly aggressive in it style of auditing (Rivers 2011a). An overemphasis on detecting fraud has made some grant implementers talk of being made to feel "guilty until proven innocent" (Aidspan 2011:3). Aside from the bad feeling this has engendered, such an approach has created new delays in the GFATM disbursement chain: with the OIG auditors getting bogged down in detail to the extent that they have fallen behind on their scheduled work plan and getting drawn into post-audit disagreements with auditees; with audits reports making too many demands on partner countries; and with some Principle Recipients now too afraid to spend GFATM monies in case the OIG asks for the money back at a future date. Even the former Executive Director of the GFATM has suggested that in addition to asking what *more* can be done to manage high-risk investments, the GFATM should be asking what *less* can be done to manage risk in lower-risk investments (Feachem 2011:1765). We return to notions of risk in the discussion section.

The domino effect of Round funding

Uganda became part of the "first learning wave" of National Strategy Applications (NSA) announced in 2008. Signaling an alternative to Round funding, the NSA was attempting to make the proposal process more applicant friendly by allowing countries to submit a national disease strategy rather than a GFATM-specific proposal form as the primary basis of applications. Uganda fulfilled several of the entry criteria for the pilot: strong partnerships

with bilateral donors and technical agencies, and at least one "well articulated and documented national strategy…" (Aidspan 2009a:1).

Unfortunately, it was stipulated that participation in the pilot was open only to countries that had applied for, but were unsuccessful, in their application for Round 8. Despite the disruption to the HPAC and PC forums, and the use of the Partnership Funds to contract external expertise, the final proposal was never submitted. The increased work required for each round, and the dissatisfaction of the GFATM with this resulted in series of constant delays that impinged on each round (an issue that was even reflected on in the local media; Wendo and Businge 2008). The failure of Uganda to submit a Round 8 proposal points to two key issues: the delay in signing off on the approved Round 7 grants and the ramifications of that delay for future GFATM applications.

The Round 7 HIV/AIDS and malaria grants were approved in November 2007, but release of resources were dependent on the meeting of certain "condition precedents". (It was dealing with these in Nepal in association with Round 7 funding for TB – including the setting up of a Program Management Unit to better monitor the outcomes and financial flows - that occupied all of Harper's time over a five month period working in Nepal at the request of the government). As interlocutors in Uganda pointed out this could well take up to 16 months before funds start flowing (Interview MOH official, 16th April 2008). Uganda is not alone: Inefficiencies in the GFATM's disbursement processes have been picked up in a number of studies (Donoghue *et al.* 2005). The Round 7 application for TB in Uganda had been turned down by the GFATM:

> "We got feedback [from the Technical Review Panel] although some people say one of the things that's not written in the feedback is that at the time of the application for Round 7, Round 6 had not been signed. So some people were saying we're probably not even wise at all to ask for more money when the other one is not signed even" (Interview 22nd April 2008).

Despite the GFATM's commitment to transparency, we could find no clarification on this point in the voluminous material on their website. In Nepal there was certainly a disjuncture

between teams in Geneva working on the differing rounds, with poor communication, and they were evaluated as separate entities, which may go some way to explaining this. Despite the effort and resources Uganda put into developing Round 8 they still pulled out at the last minute, and so it seems that their capacity is still not capable of dealing with the increased workload.

Uganda was not involved in the "second wave" of the NSA pilot rolled out in 2011. Nevertheless, the events that have overtaken the GFATM in 2011/12 have signaled an abrupt end to Round funding. While a Transitional Funding Mechanism was put in place to carry on essential services following the cancellation of Round 11 (Rivers 2011c), the GFATM Secretariat is now in the process of devising a wholly new funding model (for details see GFATM 2011a; GFATM 2011c). In keeping with the analogy of the GFATM experiment however, the exact specifications of the new model are not yet available, despite some indications that the GFATM may be in a position to issue a call for proposals as early as September 2012 (Garmaise 2012b).

DISCUSSION

In its first decade of operation the GFATM vision of a simplified and rapid disbursement mechanism in the context of Uganda has clearly not materialized. Driven by the GFATM needs, we have demonstrated how this results in the over bureaucratization of processes and governance structures in country. One framing for understanding this is linked to an inability of GFATM to manage risk. Indeed, the *Five-Year Evaluation of the GFATM* points to the failure of the Fund to effectively manage risk, finding that "The lack of a robust risk management strategy during its first five years of operation has lessened the Global Fund's organization efficiencies and weakened certain conditions for the effectiveness of its investment model" (Macro International 2009:44). Business theory – and the GFATM model mirrors the exigencies of business models - dictates that risk isn't a thing to be avoided but something to be managed, because ultimately "risk will never be eliminated from high-risk systems" (Perrow 1999:4; also see Dörner 1996). It was in this vein, that an earlier study of

the GFATM suggested applicant countries be risk assessed and categorized according to the results (Booz Allen Hamilton 2007). The Fund's *Consolidated Transformation Plan* sets out its intentions to pursue a calibrated approach to risk management based on the risk environment and to appoint a dedicated Chief Risk Officer to oversee the global portfolio (GFATM 2011a; also see GFATM 2012). Discursively, the GFATM's unresolved relationship with risk evokes the imagery of both the *Risk* and the *Audit Society* described by Beck (1992) and Power (1997) (also see Giddens 1999). While this may go some way to understanding the GFATM case material, it is interpretively limited, as it is precisely the organizations focus on risk that generates these structures and increasingly dense governance modalities.

In anthropology, the post structural turn in the anthropology of development has led to a shift viewing development practices through the theoretical framing of "governmentality". Ferguson's (1990) now classic monograph, *The Anti-Politics Machine*, was a starting point for this literature. Using a post-structural frame, he analyzed how development institutions, in particular the World Bank (with reference to Lesotho) constituted the idea of the "Less Developed Country" (LDC), in order to create it as a target for development interventions. We have shown how Uganda fits with this logic.

However, a number of ethnographies have followed in this vein, remaining deeply influenced by the post-structural theoretical turn, while enriching and developing the ethnographic critique. In particular, David Mosse's corpus of writing has shown how much work, and the complexity of the networks, goes into the developing and stabilizing of the frames developed by development institutions. He, along with others (see for example Watts 2001) have taken writers such as Ferguson to task for the lack of attention they pay to the complexities and nuances of policy development and to "the creativity and skill involved in negotiating development" (2005:2). We also pay heed to this, and to Nichter's call for Medical Anthropologists to pay attention to the ways in which shifts in financial support, in particular for very visible vertical programs (like TB, HIV and Malaria) impact on broader health care agendas (Nichter 2008).

The ethnography presented here foregrounds the complexities and political (or anti-political) work involved in the unfolding of the GFATM's mandate and vision. To some extent it is indicative of the "new managerialism" in development (Mosse 2005:3) whereby micro-accountability and transparency are touted as the antidote to politically-driven aid. The unplanned consequence of the donor efficiency drive and attempts to make decision-making more visible has been the excessive bureaucratization of development, the burden for which falls most heavily on the shoulders of the aid recipients. This is not the self-represented GFATM idea of "partnership", but rather the dense entanglement of other donors and government partners into networks of relations that generate the requisite paperwork and forms of surveillance. It is extraordinary how much hard work, and adaptive strategies all those involved in the scheme put into attempts to stabilize these forms. The maintenance of these relationships trump the policy, and as Mosse has argued, seem to be more important than the policy itself (which was and remains unstable, constantly evolving due to the GFATM's experimental approach). The maintenance of these relationships is essential to keep the resources flowing into the country, while simultaneously acting as impediments to this.

But despite the increased flow of resources, the associated and increasing bureaucratization has wide ranging unintended effects. The international health literature is replete with discussion of the impact of vertical programs, and the move away from universal health care delivery. Much of this is ideologically driven. The Uganda material presented here, however, clearly demonstrates the insidious effects of this at the level of institutional coordination and relations at the level of the state. The additional resources coming into the health sector do not supplement existing approaches, the initial driving force for the Fund. Rather, its very modalities of activity in country act against a broader approach to health care, and drain resources from other areas. The inability to disburse funds efficiently has thus placed the GFATM in a position where its poor reputation, may put its very survival at stake. This has serious ramifications for the inroads made by the Fund in HIV/AIDS, tuberculosis and malaria. Reports on the stagnating HIV/AIDS prevalence rate in Uganda

(UAC 2007) and the resurgence of malaria in Rwanda (Feachem 2011) remind us that a lot of people are depending on the GFATM experiment to work. How countries such as Uganda are entrusted with funds needs to be re-conceptualized by the GFATM Secretariat and offset against the desire to control and manage risk. An understanding generated through thick ethnography – stepping outside of the existing frames of reference that the organizations involved in the process generate – and that highlights the consequences of policy and actions may be a starting point for imagining other ways of resource delivery, ones that do not reify distinctions between the "big three" infectious diseases, and the rest of health service delivery.

NOTES

1. http://www.theglobalfund.org/en/about/whoweare/, accessed September 8, 2012.
2. http://www.theglobalfund.org/en/performancebasedfunding/, accessed September 8, 2012.
3. 'Donor darling' is a staple term used by both the media and academia when discussing Uganda's international reputation. For examples see Cargill (2004) and Green (2008).
4. Rather than being contained in one document, Uganda's LTIAs have been refined via a series of documents. The document cited in this article is: 2006 Proposed Long Term Institutional Arrangements for the programmes of the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) in Uganda. Hard Copy.

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